New Patient Information: (Please Print)

Patient's Legal Name:
Last____________________________________First________________________________ MI_____

Male / Female Birth date__________________________Age_______
SSN#_________________________________

Patient's Address
____
Home Phone _________________________ Work Phone__________________________
Cell Phone ________________________________

Who referred you to our office?____

If the patient is a minor, please list both parents and employers:

Mother_____________________________Employer____________________Phone_________________
Father_____________________________Employer____________________Phone________________

Work Related Injury (NOT AN INJURY SKIP SECTION)

Is your injury work related? Y N
If yes, Date of Injury: ________________________________

Insurance Co.__________________________________
Adjuster/Case Mgr.___________________________ Phone_________________

Is your injury due to an accident? Y N
If yes: MVA / OTHER Have you obtained an accident report? _______
Are you currently involved in any litigation? Y N If yes, with whom?
____

Attorney:____Phone ___________________

I hereby authorize my insurance benefits to be paid directly to the facility and the physician. I understand that I am financially responsible for Non-covered services. I authorize the physician to release my information in the processing of any insurance claim.

Signature:____

Chief
Complaint____

Date the pain began ____

What events led to your pain? ____
____

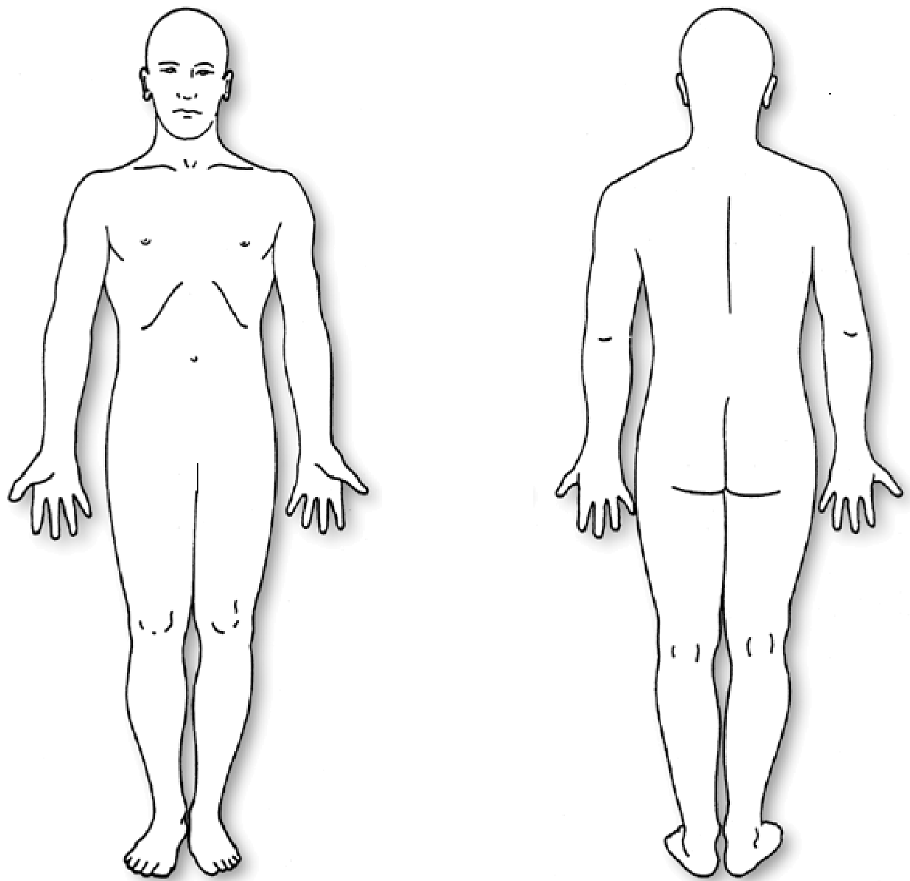
Describe your pain____
____

Please describe your pain:

Use the pictures below to mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark the areas of radiation by using arrows and include all affected areas.

NUMBNESS:

_____
_____
_____



PINS AND NEEDLES:

OOOOO
OOOOO
OOOOO

BURNING:

XXXXX
XXXXX
XXXXX

STABBING:

///////
///////
///////

Location of pain

Burning Y N ___________________________________
Tingling/ Pins and Needles Y N ___________________________________
Aching Y N ___________________________________
Coldness Y N ___________________________________
Throbbing Y N ___________________________________
Numbness Y N ___________________________________
Sharp Y N ___________________________________

Skin Discoloration Y N ___________________________________
Dull Y N ___________________________________
Muscle Spasm Y N ___________________________________
Shooting Y N ___________________________________
Muscle Tightness Y N ___________________________________
Stabbing Y N ___________________________________
Bowel/Bladder Problems Y N ___________________________________
Swelling Y N

Have you been hospitalized for your pain? Yes No
If Yes, please give the date, facility and physician who cared for you:

____

____

What time of the day is your pain at its worst?

____

On average, how many hours do you sleep?

____

If you have low back and leg pain, indicate percentage:
back__________% leg___________%

Using Pain Scale of 0-10, Rate your pain. 0=No pain 10=worst pain ever

At its Worst:	0	1	2	3	4	5	6	7	8	9	10
At its least:	0	1	2	3	4	5	6	7	8	9	10
At its usual:	0	1	2	3	4	5	6	7	8	9	10
Today:	0	1	2	3	4	5	6	7	8	9	10

How do the following affect your pain?

B=makes better **W**=makes worse **N**=no effect

Relaxation	B	W	N	Standing	B	W	N
Heat	B	W	N	Walking	B	W	N
Cold	B	W	N	Lying Down	B	W	N
Alcoholic Drinks	B	W	N	Exercise	B	W	N
Medication	B	W	N	Sexual Activity	B	W	N
Sitting	B	W	N	Coughing/Sneezing	B	W	N

Previous Treatments:

Injections or Blocks Y N If yes, please give the date, facility and physician name:

____

____

Physical Therapy Y N

____

Chiropractor Y N

____

Acupuncture Y N

____

Hypnosis Y N

____

TENS Unit Y N

____

Mental Health Y N

____

Testing: If yes, please list date and treatment facility name:

Lumbar MRI/CT Y N

____

Cervical MRI/CT Y N

____

Thoracic MRI/CT Y N

____

Myelogram Y N

____

EMG Y N

____

Discogram Y N

____

Bone Scan Y N

____

Social History:

Do you object to a blood transfusion? Y N

Drink alcohol? never occasionally frequently daily

Use street drugs or have a history of addiction or abuse? Y N

Use tobacco? Y N If yes, packs per day: _________ smokeless tobacco? Y N

Are you now or is there a possibility of you being pregnant? Y N Maybe NA

Number of Children_________

Marital Status Married____ Single____ Divorced____ Widowed____

Separated____

Occupation:____

Are you currently working? Y N

If not, last day worked: ______________________________

Medical Problems that run in your family:

____

Medical History (Do you have or have you ever had the following?)

Condition			Condition		
Arthritis	Y	N	Anticoagulant Therapy	Y	N
Glaucoma	Y	N	Lung Disease	Y	N
Cataracts	Y	N	COPD/Emphysema	Y	N
Back Trouble	Y	N	Jaundice	Y	N
Blood Disease	Y	N	Paralysis	Y	N
Stroke	Y	N	Thyroid Disease	Y	N
HIV/AIDS	Y	N	Psychiatric Disorder	Y	N
Depression	Y	N	Abnormal EKG	Y	N
Cancer	Y	N	Anxiety	Y	N
Epilepsy/Seizures	Y	N	Muscle Weakness	Y	N
High Cholesterol	Y	N	High Blood Pressure	Y	N
Heart Attack	Y	N	Fracture of Facial Bones	Y	N
Heart Murmur	Y	N	Kidney Disease	Y	N
Hepatitis	Y	N	Stomach Disorder	Y	N
Mononucleosis	Y	N	Asthma	Y	N
Fracture	Y	N	Muscular Disorder	Y	N
Diabetes	Y	N	Bone Disease	Y	N
Blood Transfusion	Y	N	Infection	Y	N

Past Surgical History:

____

____

____

Any hospitalizations in the past year other than for above surgery? Y N
If yes please give details:

____

____

List all PAIN medications:

Medication	**Dose**	**Frequency**	**Prescribing Physician**

List all other medications, including over the counter medications, vitamins and herbal supplements:

Medication	**Dose**	**Frequency**

Do you take any blood thinning medications such as Plavix, Coumadin, Warfarin, Aggrenox, Heparin or Aspirin?

Y N If yes, please list:____

Cardiologist:

____

Medication Allergies:

____

Do you **currently** have any of the following symptoms?

Fever Y N

Weight loss Y N

Weight gain Y N

Night sweats Y N

Chills Y N

Malaise Y N

Dry eyes Y N

Vision change Y N

Wear glasses Y N

Hearing loss Y N

Ear pain Y N

Nose bleeds Y N

Sinus problems Y N

Sore throat Y N

Dry mouth Y N

Snoring Y N

Ringing in ears Y N

Chest pain Y N

Palpations Y N

Ankle swelling Y N

Difficulty breathing Y N

Cough Y N

Wheezing Y N

Sleep apnea Y N

Abdominal pain Y N

Nausea Y N

Vomiting Y N

Constipation Y N

Symptom	Y	N	Symptom	Y	N
GERD	Y	N	Numbness	Y	N
Diarrhea	Y	N	Seizures	Y	N
Incontinence	Y	N	Dizziness	Y	N
Urinary pain	Y	N	Migraines	Y	N
Blood in urine	Y	N	Headaches	Y	N
Muscle aches	Y	N	Depression	Y	N
Muscle weakness	Y	N	Anxiety	Y	N
Joint pain	Y	N	Suicidal thoughts	Y	N
Back pain	Y	N	Fatigue	Y	N
Neck pain	Y	N	Bruising	Y	N
Joint swelling	Y	N	Bleeding	Y	N
Skin rash	Y	N	Dry skin	Y	N
Non healing area	Y	N	Runny nose	Y	N
Change to hair	Y	N	Sinus pressure	Y	N
Weakness	Y	N	Itching	Y	N